
Wisconsin Chronic Disease Program Companion Document to HIPAA Implementation Guide: 837 Professional

Companion Document Audience

Companion documents are intended for information technology and/or systems staff who will be coding billing systems or software for compliance with the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Purpose of Companion Documents

The information contained in this companion document applies to Wisconsin Chronic Disease Program (WCDP).

The companion documents are designed to be used with HIPAA Implementation Guides. Companion documents provide WCDP-specific information that details the way to create HIPAA transactions for WCDP and explains how WCDP creates HIPAA transactions. Companion documents clarify the HIPAA-designated standards usage but are not intended to supercede them. The purpose of companion documents is to provide trading partners with a guide to communicate the WCDP-specific information required to successfully exchange transactions electronically with WCDP.

WCDP will accept and process 837 HIPAA-compliant transactions. However, a compliant transaction that doesn't contain WCDP-specific information, though processed, may be denied for payment. For example, a compliant 837 Professional claim created without a valid WCDP covered diagnosis code will be processed by WCDP, but will be denied payment. WCDP will not accept 837 Dental claims. Please submit dental claims on paper.

Companion documents highlight the data elements significant for WCDP. For transactions created by WCDP, companion documents explain how certain data elements are processed. Please refer to the companion document first if there is a question about how WCDP processes a HIPAA transaction.

If your facility will be using the PES software to submit claims to Wisconsin Medicaid, please be aware this claim submission software is not compatible with the WCDP system. The PES software provided by Wisconsin Medicaid does not have the required fields needed to submit claims to WCDP.

For further information, contact the Division of Health Care Financing (DHCF) Electronic Data Interchange (EDI) Department at (608) 221- 9036.

X12 837 Health Care Claim: Professional

Loop	Element	Name	Instructions
	ISA	Interchange control header	The ISA is a fixed-length record with fixed-length elements. <i>Note:</i> Deviating from the standard's ISA element sizes will cause the interchange to be rejected.
	ISA05	Interchange ID (sender) qualifier	Enter the value "ZZ", mutually defined.
	ISA06	Interchange sender ID	Enter the eight-digit numeric vendor number assigned by Wisconsin Medicaid.
	ISA07	Interchange ID (receiver) qualifier	Enter the value "ZZ", mutually defined.
	ISA08	Interchange receiver ID	Enter "WISC_DHFS".
	GS02	Application sender's code	Enter the same value as ISA06, the eight-digit numeric vendor number assigned by Wisconsin Medicaid.
	GS03	Application receiver's code	Enter "WISC_WCDP" for WCDP.
	GS08	Version / release / industry identifier code	Enter the value "004010X098A1", the HIPAA mandated implementation guide release for this transaction. <i>Note:</i> This code represents the HIPAA implementation guide with the most recent addenda changes. Using an earlier guide, without the most recent addenda changes, does not comply with the HIPAA rule and will cause the transaction to be rejected.

Loop	Element	Name	Instructions
	BHT03	Reference identification	Make this identifier unique to a single transaction (ST to SE envelope). Repeating a value will cause the transaction to be rejected. WCDP recommends using a value with an easily identifiable pattern to aid research (e.g., "ANY_GROUP_PRACTICE_20031016" or "ANY GROUP PRACTICE #00001").
	REF02	Reference identification	Enter the value "004010X098A1" to indicate professional claim. <i>Note:</i> This version includes the addenda.
1000A	NM109	Submitter identifier	Enter the same value as ISA06, the eight-digit numeric vendor number assigned by Wisconsin Medicaid. <i>Note:</i> A new vendor number will be issued for submitting HIPAA transactions. This number will replace the submitter's current vendor number.
1000B	NM101	Entity identifier code	Enter the value "40" for receiver.
1000B	NM102	Entity type qualifier	Enter the value "2" for non-person entity.
1000B	NM103	Receiver name	Enter "WCDP" to indicate the claims are being sent to WCDP.
1000B	NM108	Identification code qualifier	Enter the value "46" for electronic transmitter identification number.
1000B	NM109	Identification code or receiver primary identifier	Enter the same value as GS03, "WISC_WCDP" for WCDP.

Loop	Element	Name	Instructions
2000A	PRV01	Provider code	Enter the value "BI" to indicate the rendering/performing provider is the same entity as the billing provider or enter "PT" to indicate the rendering/performing provider is the same entity as the pay-to provider.
2010AA	REF	Billing provider secondary identification	Include this segment if the provider in loop 2010AA is the provider certified by Wisconsin Medicaid to submit claims. <i>Note:</i> WCDP requires all claims be submitted with the Wisconsin Medicaid billing provider number.
2010AA	REF01	Reference identification qualifier	Enter the value "1D" for the Medicaid provider number.
2010AA	REF02	Billing provider additional identifier	Enter the eight-digit Wisconsin Medicaid billing provider number.
2010AB	NM1	Pay-to provider name	<i>Note:</i> The information in this segment will not be used to determine where to send the provider Remittance and Status Report (R/S). The R/S Report will be sent to the entity established during the provider certification process.
2010BA	NM1	Subscriber name	Enter information about the subscriber/recipient in this loop.
2010BA	NM102	Entity type qualifier	Enter the value "1" to indicate the subscriber is a person.
2010BA	NM103	Subscriber last name	Enter the recipient's last name. <i>Note:</i> Use the WCDP identification card to obtain the correct spelling of the recipient's last name.

Loop	Element	Name	Instructions
2010BA	NM104	Subscriber first name	<p>Enter the recipient's first name.</p> <p><i>Note:</i> Use the WCDP identification card to obtain the correct spelling of the recipient's first name.</p>
2010BA	NM108	Identification code qualifier	<p>Enter the value "MI" for member identification number.</p>
2010BA	NM109	Subscriber primary identifier	<p>Enter the recipient's 10-digit WCDP identification number.</p> <p><i>Note:</i> First digit of the ID must be either a K, C or H. Use the WCDP identification card to obtain the correct identification number.</p>
2300	CLM01	Patient account number	<p><i>Note:</i> WCDP will process patient account numbers up to 20 characters in length.</p>
2300	CLM02	Total claim charge amount	<p>Enter the total billed amount for the entire claim.</p> <p><i>Note:</i> WCDP will process claims submitted with a negative total billed amount as if the provider submitted a zero total billed amount.</p>
2300	CLM05-3	Claim frequency code	<p>The third digit of the type of bill, as defined by the National Uniform Billing Committee (NUBC) is the frequency. Use the claim frequency code to indicate if the claim is being submitted for the first time. WCDP will not be accepting electronic adjustments.</p> <ul style="list-style-type: none"> • WCDP will treat all claim frequency codes as if submitted as a "1". • All requests for adjustments (replacement/void of a previously adjudicated claim or paid claim) must be submitted on paper with supporting documentation using the WCDP claim adjustment form located in the WCDP Provider Handbook.

2300	REF01	Reference identification qualifier	Enter the value "EA" for MRN.
2300	REF02	Medical record number	Enter the MRN.
2300	HCP01	Indicator	Enter the value "10" for Other Pricing. All WCDP Chronic Renal Disease Professional claims must provide the Medicare Allowed amount. <ul style="list-style-type: none"> This field is not required for Hemophilia Home Care or Adult Cystic Fibrosis claims.
2300	HCP02	Medicare Allowed Amount	Enter the total Medicare Allowed amount for the claim in this segment. WCDP Chronic Renal Disease Program claims will deny if this field is not populated with the Medicare allowed amount.
2300	HI	Health care diagnosis code	Enter the diagnosis in this segment. <i>Note:</i> WCDP will use up to five diagnosis codes to process a claim, however a WCDP covered diagnosis code must be entered as the primary diagnosis code for the claim to pay successfully. The principal diagnosis code is included in the five.
2300	HI01-1	Diagnosis type code	Enter the value "BK" for principal diagnosis.
2300	HI02-1	Diagnosis type code	Enter the value "BF" for each additional diagnosis code.
2300	HI02-2 HI03-2 HI04-2 HI05-2	Diagnosis code	Enter additional diagnosis codes in order of importance.
2310A	NM101	Entity identifier code	Enter the value "DN" for referring provider.

Loop	Element	Name	Instructions
2310A	NM103	Referring provider last name	Enter the referring provider's last name.
2310A	REF	Referring provider secondary identification	Include this segment when the referring provider has a Medicaid provider number.
2310A	REF01	Reference identification qualifier	Enter the value "1D" for Medicaid number.
2310A	REF02	Referring provider secondary identifier	Enter the eight-digit individual provider number assigned by Wisconsin Medicaid.
2310B	REF	Rendering provider secondary identification	Enter the rendering(performing) provider's Medicaid identification number in this segment if the performing provider is Medicaid certified and different then the Wisconsin Medicaid billing provider.
2310B	REF01	Reference identification qualifier	Enter the value "1D" for Medicaid number.
2310B	REF02	Rendering provider secondary identifier	Enter the eight-digit provider number assigned by Wisconsin Medicaid.

Loop	Element	Name	Instructions
2320	SBR	Other Subscriber Information	<p>Include this loop when any of the following occur:</p> <ul style="list-style-type: none"> • The claim will be processed by multiple payers. • The recipient has commercial health insurance or commercial HMO coverage, but the claim was not billed to the other payer for reasons including, but not limited to: <ul style="list-style-type: none"> ◆ The recipient denied coverage or will not cooperate. ◆ The provider knows the service in question is not covered by the carrier. ◆ The recipient's commercial health insurance failed to respond to initial and follow-up claims. ◆ Benefits are not assignable or cannot get assignment. ◆ Benefits are exhausted. • The claim was not sent to Medicare Part A, the billing provider identified is certified for Medicare Part A, the recipient is eligible for Medicare Part A, and the service is usually covered by Medicare Part A but not in this circumstance. • The claim was not sent to Medicare Part B, the billing provider identified is certified for Medicare Part B, the recipient is eligible for Medicare Part B, and the service is usually covered by Medicare Part B but not in this circumstance.

Loop	Element	Name	Instructions
2320	SBR09	Claim Filing Indicator Code	<p>Enter the type of payer. WCDP uses this information when evaluating other insurance information.</p> <p>If this claim was not submitted to a commercial health insurance plan or commercial HMO plan based on the reasons listed for the SBR segment in loop 2320, use one of the following values:</p> <ul style="list-style-type: none"> • "12" for Preferred Provider Organization (PPO). • "13" for Point of Service (POS). • "14" for Exclusive Provider Organization (EPO). • "BL" for Blue Cross/Blue Shield. • "CH" for Champus. • "CI" for Commercial Insurance Co. • "DS" for Disability. • "HM" for Health Maintenance Organization. • "VA" for Veteran Administration Plan. <p>If this claim was not submitted to Medicare based on the reasons listed for the SBR segment in loop 2320, use one of the following values:</p> <ul style="list-style-type: none"> • "MB" for Medicare Part B. • "16" for Health Maintenance Organization Medicare Risk

Loop	Element	Name	Instructions
2320	CAS	Claim level adjustments	<p>Include this segment when another payer has made payment at the claim level. If the other payer returned an 835 HealthCare Claim Payment/Advice, the CAS segment from the 835 should be copied to this CAS.</p> <p><i>Note:</i> WCDP will use the information in the CAS segment in place of the "other insurance indicator" and "Medicare disclaimer code" submitted prior to HIPAA.</p> <p>If this iteration of loop 2320 contains information from a Medicare payer, WCDP will also look for Medicare's coinsurance, copayment and deductible in this segment.</p>
2320	AMT	Coordination of benefits (COB) payer paid amount	This segment contains the amount paid on this claim by the payer within this 2320 loop.
2320	AMT01	Amount qualifier code	Enter the value "D" for payer amount paid.
2320	AMT02	Payer paid amount	Enter the amount paid on this claim by the payer within this 2320 loop.
2320	AMT	Coordination of benefits (COB) allowed amount	<p>Enter how much the other payer allowed in this segment.</p> <p>** Do not use this segment to indicate the Medicare Allowed amount for WCDP Chronic Renal disease claims. Use field 2300 HCP01 and HCP02 to indicate the Medicare allowed amount.</p> <p>If this iteration of 2320 is being used to indicate the claim was not submitted to another payer based on the notes in the SBR segment of loop 2320 of this document, include this segment.</p>
2320	AMT01	Amount qualifier code	Enter the value "B6" for allowed amount.

Loop	Element	Name	Instructions
2320	AMT02	Allowed amount	Enter the other payer's allowed amount. <i>Note:</i> If the claim was not submitted to another payer, a zero must be used as the allowed amount.
2320	MOA	Medicare outpatient adjudication information	Include this segment when it was returned in the 835 HealthCare Claim Payment/Advice from a previous payer or if this iteration of 2320 is being used to indicate that the claim was not submitted to another payer based on the notes in the SBR segment of loop 2320 of this document.
2320	MOA03	Remark code	If the claim was not submitted to another payer, enter "MA07" in this element.
2330B	NM109	Other payer primary identifier	Enter the other payer's identifier. <i>Note:</i> WCDP will use this number in combination with loop 2430 to calculate other insurance and Medicare payments.
2330B	DTP	Claim adjudication date	Enter the date Medicare paid the claim in this segment if the recipient is a dual-entitlee and loop 2320 contains information about the Medicare payer. <i>Note:</i> This information is either included here or in loop 2430.
2330B	DTP01	Date/time qualifier	Enter "573" for date claim paid.
2330B	DTP02	Date time period format qualifier	Enter the value "D8" for format ccyymmdd.
2330B	DTP03	Adjudication or payment date	Enter Medicare's claim paid date.
2400	SV101-1	Product or service ID qualifier	Enter the value "HC" for Healthcare Common Procedure Coding System (HCPCS).

Loop	Element	Name	Instructions
2400	SV101-2	Procedure code	Enter the HCPCS code for the procedures performed.
2400	SV102	Line item charge amount	Enter the billed amount for each service line. <i>Note:</i> WCDP will process claims with a negative service line billed amount as if the provider submitted a zero service line billed amount.
2400	SV103	Unit or basis for measurement code	Enter the value "MJ" for minutes or "UN" for units.
2400	SV104	Service unit count	Enter the number of minutes or units for the services provided.
2400	SV107-1	Diagnosis code pointer	Enter a value of 1 through 5 corresponding to the primary diagnoses in element HI01-2, HI02-2, HI03-2, HI04-2, HI05-2
2400	SV109	Emergency indicator	Enter the value "Y" if the services were performed as a result of an emergency.
2400	DTP01	Date/time qualifier	Enter the value "472" for service dates.
2400	DTP02	Date time period format qualifier	Enter value "D8" to indicate a single date of service or "RD8" to indicate a range of service dates. <i>Note:</i> When "RD8" is used, WCDP will assume the exact same service, including the number of units, was performed on each day within the range.
2400	DTP03	Service date	Enter the date(s) the procedure was performed.
2400	REF01	Reference identification qualifier	Enter the value "6R" for provider control number.
2420A	REF	Rendering provider secondary identification	Enter the rendering(performing) provider Medicaid identification number in this segment if the performing provider is Medicaid certified and different then the Wisconsin Medicaid billing provider.

Loop	Element	Name	Instructions
2420A	REF01	Reference identification qualifier	Enter the value "1D" for Medicaid number.
2420A	REF02	Rendering provider secondary identifier	Enter the eight-digit Wisconsin Medicaid provider number.
2420F	NM101	Entity identifier code	Enter the value "DN" for referring provider.
2420F	NM103	Referring provider last name	Enter the referring provider's last name.
2420F	REF01	Reference identification qualifier	Enter the value "1D" for Medicaid number.
2420F	REF02	Referring provider secondary identifier	Enter the eight-digit individual provider number assigned by Wisconsin Medicaid.
2430	SVD01	Other payer primary identifier	Enter the other payer's primary identifier if another payer has paid on the service line.
2430	SVD02	Service line paid amount	Enter the amount the other payer paid on the service line.
2430	CAS	Line adjudication information	<p>Include this segment when another payer has made payment at the service line. If the other payer returned an 835 remittance, the CAS segment from the 835 should be copied to this CAS.</p> <p><i>Note:</i> WCDP will use the information in the CAS segment in place of the "other insurance indicator" and "Medicare disclaimer code" submitted prior to HIPAA.</p> <p>If this iteration of loop 2430 contains information from a Medicare payer, WCDP will also look for Medicare's coinsurance, copayment and</p>

Loop	Element	Name	Instructions
			deductible.
2430	DTP	Line adjudication date	Include this segment when another payer has made payment at the service line of this claim.
2430	DTP01	Date/time qualifier	Enter the value "573" for the claim paid date.
2430	DTP02	Date time period format qualifier	Enter the value "D8" to indicate format ccyymmdd.
2430	DTP03	Adjudication or payment date	Enter the date the other payer paid the claim.